

REGISTRATION FORM**PARENT/GUARDIAN # 1 INFORMATION (Must provide information on all adults in the household)**

Last name:	First name:	Primary language:
Street address:	City:	Zip Code:
Home phone:	Work phone:	Cell phone:

Are you currently receiving cash aid? ☐ Yes ☐ No If **NO**, have you received cash aid within the last two years? ☐ Yes ☐ No
 If **YES** last date of cash aid payment: ____/____/____

REASON FOR NEEDING CHILD CARE (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Working (Employer's Name/Zip Code:) _____ | <input type="checkbox"/> Looking for Work |
| <input type="checkbox"/> Attending School or Job Training (Name of School/Zip Code:) _____ | <input type="checkbox"/> Homeless/Seeking housing |
| <input type="checkbox"/> Medically Incapacitated/Disabled | <input type="checkbox"/> Part-day preschool experience for child ONLY |
| | <input type="checkbox"/> Migrant Worker |

INCOME (Write total dollars, before taxes and deductions, for each source of income)

MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE
\$	Wages/salaries or income from self-employment	\$	Spousal Support	\$	Food Stamps
\$	Social Security Benefits	\$	State Disability	\$	Unemployment benefits
\$	Worker's Compensation	\$	Child Support	\$	Pensions/Annuities
\$	State Supplemental income	\$	Adoption Subsidies	\$	Cash Aid (children only)
\$	Other:	\$	If you <u>pay out</u> child support, how much is it per month?		

PARENT/GUARDIAN # 2 INFORMATION

Last name:	First name:	Primary language:
Home phone:	Work phone:	Cell phone:

Are you currently receiving cash aid? ☐ Yes ☐ No If **NO**, have you received cash aid within the last two years? ☐ Yes ☐ No
 If **YES** last date of cash aid payment: ____/____/____

REASON FOR NEEDING CHILD CARE (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Working (Employer's Name/Zip Code:) _____ | <input type="checkbox"/> Looking for Work |
| <input type="checkbox"/> Attending School or Job Training (Name of School/Zip Code:) _____ | <input type="checkbox"/> Homeless/Seeking housing |
| <input type="checkbox"/> Medically Incapacitated/Disabled | <input type="checkbox"/> Part-day preschool experience for child ONLY |
| | <input type="checkbox"/> Migrant Worker |

INCOME (Write total dollars, before taxes and deductions, for each source of income)

MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE
\$	Wages/salaries or income from self-employment	\$	Spousal Support	\$	Food Stamps
\$	Social Security Benefits	\$	State Disability	\$	Unemployment benefits
\$	Worker's Compensation	\$	Child Support	\$	Pensions/Annuities
\$	State Supplemental income	\$	Adoption Subsidies	\$	Cash Aid (children only)
\$	Other:	\$	If you <u>pay out</u> child support, how much is it per month?		

CHILDREN LIVING AT HOME (All children in the household under 18 or under age 22 if disabled)

#1. First Name				Last Name			
Birth date:		Gender: M F		Preferred Zip codes for care:			
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE							
Child School Name / Grade:				District:			
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE							
Foster Care Payments		Social Worker's Name		Contact Number		Case Number	
\$							
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No				List related siblings in the same household:			
Referred by: _____							
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:							

#2. First Name				Last Name			
Birth date:		Gender: M F		Preferred Zip codes for care:			
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE							
Child School Name / Grade:				District:			
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE							
Foster Care Payments		Social Worker's Name		Contact Number		Case Number	
\$							
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No				List related siblings in the same household:			
Referred by: _____							
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:							

#3. First Name				Last Name			
Birth date:		Gender: M F		Preferred Zip codes for care:			
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE							
Child School Name / Grade:				District:			
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE							
Foster Care Payments		Social Worker's Name		Contact Number		Case Number	
\$							
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No				List related siblings in the same household:			
Referred by: _____							
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:							

#4. First Name				Last Name			
Birth date:		Gender: M F		Preferred Zip codes for care:			
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE							
Child School Name / Grade:				District:			
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE							
Foster Care Payments		Social Worker's Name		Contact Number		Case Number	
\$							
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No				List related siblings in the same household:			
Referred by: _____							
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:							

CHILDREN WITH SPECIAL NEEDS, DISABILITIES OR MEDICAL CONDITIONS

<i>Check all that apply for each child listed above</i>	CHILD # 1	CHILD # 2	CHILD # 3	CHILD # 4
Child has Individual Family Services Plan (IFSP) (age 0-3)				
Child has an Individual Education Plan (IEP) ages 3 and older				
Receives Early Start/Regional Center services				
Receives services from local school district (special education)				
Developmental delays (cognitive, autism, Down syndrome, etc.)				
Developmental delays (physical motor)				
Social/Emotional delays or behavior				
Physical disability (cerebral palsy, spinal bifida, orthopedic limitations, etc.)				
Health/medical (asthma, diabetes, other _____)				
Speech/language/communication				
Hearing/vision				